STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155723	A. BUILDING _____ B. WING _____	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN47715

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F0000	This visit was for the Investigation of Complaint IN00085610 and Complaint IN00086402. Complaint IN00085610 Substantiated, Federal/State deficiencies related to the allegations are cited at F282, F333, F514 Complaint IN00086402 Substantiated, Federal/State deficiencies related to the allegations are cited at F309, F312. Survey dates: February 21, 22, and 23, 2011 Facility number: 002280 Provider number: 155723 AIM number: N/A Survey team: Anne Marie Crays RN Census bed type: SNF: 49 Residential: 37 Total: 86 Census payor type: Medicare: 29 Other: 57 Total: 86 Sample: 6 Residential sample: 2	F0000	The submission of this plan of correction does not indicate an admission by River Pointe Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of River Pointe Health Campus. This facility recognizes it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.The facility herby maintains it is in substantial complianace with the requirements of participation for comprehensive health care facilities. (for Title 18/19 programs)To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 2-24-11 Cathy Emswiller RN			

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F0282 SS=D	Based on interview and record review, the facility failed to follow the physician's orders, in that Resident C did not receive her prescribed Lexapro for 16 days, and Resident E received pain medication for 10 days past the stop date, for 2 of 6 residents reviewed for following the medication plan of care, in a sample of 6. Findings include: 1. The clinical record of Resident C was reviewed on 2/21/11 at 11:20 A.M. A Plan of Care, dated 9/27/1/0 and updated 12/26/10, indicated a problem of "Mood, Verbal expression of distress, At risk R/T [related to] history of [sic]." The interventions included, "Monitor effectiveness/side effects of medications as ordered - see current physician orders." An additional Plan of Care, dated 9/27/10 and updated 12/26/10, indicated a problem of "Psychotropic Drug Use...Anti-depressant...Diagnosis for which drug has been prescribed: Anxiety, Depression, Insomnia, Dementia." The interventions included: "Administer medication as prescribed by the physician...." A Physician's order, initially dated	F0282	Resident C and E's medication orders have been reviewed for accuracy and to assure in accordance with their plan of care.Completion Date 3-23-2011All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing the campus will ensure the plan of care is followed.Completion Date 3-23-2011An in service was provided for all nurses concerning the process of transcribing orders to the medication administration sheet. Systemic change is two nurses will check monthly rewrites to assure accuracy of orders and a time is listed for all medications per the medication order. Another systemic change is telephone orders transcribed to the medication administration sheet will be reviewed by two nurses for accuracy.Completion Date 3-23-2011Nurse managers will perform random audits of medication administration sheets to assure services provided by the campus are provided by qualified persons in accordance with each resident's written plan of care on 3 random residents 5x a week x one month then 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 month and quarterly thereafter for review and further suggestions/comments.Completion Date 3-23-2011	03/23/2011

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	9/16/10 and on the January 2011 orders, indicated, "Lexapro [an anti-depressant] 20 mg tablet Give 1 tablet daily for depression." A "Medication Error Circumstance, Assessment and Intervention" form, dated 1/20/11, indicated, "Date of error: 1/1-1/16/11...Nature of error: Medication not given...Prevention Update: Nursing education...." A Physician's Progress Note, dated 1/22/11, indicated, "...Chronic Anxiety/depression...Spoke [with] daughter who says pt. [patient] had been getting a bit down but it seems that Lexapro was missed for awhile. Back on it now...." On 2/22/11 at 9:50 A.M., during interview with the Director of Nursing [DON], she indicated the resident's medication error occurred during the "rewrite process" at the first of the month. The DON indicated there was an order for the Lexapro on the Medication Administration Record [MAR], but there was not a time listed to give it, and therefore nursing missed it from 1/1/11 to 1/16/11. 2. The closed clinical record of Resident			

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	E was reviewed on 2/21/11 at 2:00 P.M. The resident was admitted to the facility on 11/13/10. A Physician's order, dated 11/13/10, indicated, "Norco [a pain medication]7.5/325 mg [one] tab po [by mouth] q [every] 4 hrs prn [as needed] for pain x 7 days." A Plan of Care, dated 11/15/10, indicated a problem of "Pain, chronic...R/T [related to] back pain." The interventions included: "Administer, monitor effectiveness and for side effects from PRN pain medication...." A Medication Administration Record [MAR], dated November 2011, indicated there was not a stop date for the Norco order on 11/20/11, and the resident received the Norco on 10 additional days. A "Medication Error Circumstance, Assessment and Intervention" form, dated 11/30/10, indicated, "Date of error: 11-21-10, Time of error all shifts...Nature of error: Medication given after stop date...Prevention Update: Nursing education, Nursing counseling...." On 2/22/11 at 8:50 A.M., during interview with the DON, she indicated the			

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	nurse who wrote the order for the Norco didn't indicate a "stop date" on the MAR, and so it wasn't blocked off on the MAR. The DON indicated the error was found while doing the "rewrites" for December. This federal tag relates to Complaint IN00085610. 3.1-35(g)(2)			

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F0309 SS=D	Based on interview and record review, the facility failed to ensure a resident who was having loose stools didn't hold her stool softener and laxative and notify the physician timely, for 1 of 6 residents reviewed for medication use, in a sample of 6. Resident D Findings include: The closed clinical record of Resident D was reviewed on 2/21/11 at 11:50 A.M. The resident was admitted to the facility on 1/3/11. An admission Minimum Data Set [MDS] assessment, dated 1/10/11, indicated the resident required extensive assistance of two+ staff for bed mobility, transfer, and toilet use. The MDS assessment indicated the resident was frequently incontinent of bowel and bladder. Physician orders, dated 1/4/11 and on the current February 2011 orders, indicated, "Colace 100 mg capsule Give 2 capsules orally 2 times a day," and "Miralax 1 scoop in water daily." An additional physician's order, dated 1/24/11, indicated, "Miralax 17 gm Mix [with] H2O daily - Hold for diarrhea."	F0309	Resident D no longer resides in the campus.Completion Date 3-23-2011All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing the campus will ensure each rsident will receive the necessary care and services to attain or maintian the higest practicble physical, mental, and psychosocial well being, in accordance with the comprehensive assessment plan of care.Completion Date 3-23-2011Nursing staff have been in serviced concerning documentation of bowel movements and resonsponsibility to complete early warning report when a resident has loose stools. Systemic change includes using the early warning report and nurses are to print "Group B&B" report every shift to review residents with documented loose stools.Completion Date 3-23-2011DHS/designee will perform audits of the early warning reports and the Group B&B reports to ensure a resident who is having loose stools are treated appropriately. 5x a week x one month the 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date 3-23-2011	03/23/2011

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	The February 2011 Medication Administration Record [MAR] indicated the resident received the Miralax daily from 2/1 through 2/8, except for on 2/3, which was blank. The resident received Colace twice daily from 2/1 through 2/9, then refused it on 2/10. A Physician's progress note, dated 2/15/11, indicated, "Having loose stools in am 1-2 daily...on Miralax [and] Colace daily...Impression and Plan: Diarrhea - hold Miralax, Colace until diarrhea improves then start Miralax prn [as needed]." Nurses Notes included the following notation: 2/15/11 at 8:00 A.M.: "Held Prilosec 40 mg this AM D/T [due to] ABD [abdominal] cramping followed by loose stools." 2/15/11 [untimed]: "C/O [complains of] XL [extra large] loose runny stool. States I'm going every day I don't want the Colace or Miralax. N/O [new order] to D/C [discontinue] both." A Physician's order, dated 2/15/11, indicated, "Hold Miralax - Colace until diarrhea resolved...."			

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	A computer generated "Resident BM Description," dated 2/1 through 2/12, indicated the resident had the following stools: 2/3, Small formed; 2/4, X-Large Loose; 2/5, X-Large Loose; 2/6, Medium formed, 2- X-Large Loose,; 2/7, Medium formed; 2/8, Large Loose; 2/9, X-Large Loose; 2/11, Soft Large...." On 2/22/11 at 8:50 A.M., during interview with the Director of Nursing [DON], she indicated the nursing staff can run a "BM report." The DON indicated if a resident was having loose stools, the CNA should report it to the nurse, who would notify the physician. This federal tag relates to Complaint IN00086402. 3.1-37(a)			

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F0312 SS=D	Based on observation, interview, and record review, the facility failed to ensure a resident dependent for toileting was toileted and repositioned out of her wheelchair at least every 2 hours, for 1 of 3 residents reviewed for toileting, in a sample of 6. Resident A Findings include: On 2/21/11 at 8:55 A.M., during the initial tour, the Director of Nursing [DON] indicated Resident A had a history of Urinary Tract Infections. On 2/21/11 at 9:45 A.M., Resident A was observed sitting in a wheelchair by the nurses station, asleep. A request was made at that time of LPN # 1 to observe any hands-on care that was provided to Resident A. LPN # 1 then checked with CNA # 1, and indicated the resident "had already had her shower, so it would probably be after lunch before she was laid down." The clinical record of Resident A was reviewed on 2/21/11 at 10:20 A.M. Diagnoses included, but were not limited to, Alzheimer's Disease. A Minimum Data Set [MDS] assessment, dated 2/11/11, indicated the resident	F0312	Resident A suffered no ill effects from the alleged deficient practice. Resident A's toileting needs have been assessed and her care plan was updated as appropriate.Completion Date 3-23-2011All other dependent residents have the potential to be affected by the alleged deficient practice and through changes in provision of care and in servicing the campus will prevent the recurrence of the deficient practice.Completion Date 3-23-2011Nursing staff have been in serviced on resident's plan of care and C.N.A. assignment sheets for toileting and repositioning needs. Systemic change is the implementation of a new C.N.A. assignment sheet that reflects the resident's plan of care.Completion Date 3-23-2011DHS and/or designee will monitor compliance with toileting and repositioning of a dependent resident per the plan of care on 3 random residents 5 x week x one month then 3 x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date 3-23-2011	03/23/2011

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	scored a 5 out of 15 on a cognitive assessment, required the extensive assistance of one staff for bed mobility, transfer, and toilet use, and was always incontinent of bowel and bladder. A Plan of Care, dated 6/7/10 and updated 2/18/11, indicated a problem of "Resident is incontinent of bowel, bladder R/T [related to]: Cognitive Impairment, Physical Functioning." Interventions included: "Provide incontinence care after each episode of incontinence... Wear incontinence product at all times...Ensure call light is within reach. Answer call light promptly." A Plan of Care, dated 6/7/10 and updated 2/18/11, indicated a problem of "Potential Alteration in Skin Integrity R/T [related to] Decreased mobility, Incontinence." The Interventions included, "Turn and reposition every two hours, Provide incontinence care after each incontinent episode." On 2/21/11 at 11:00 A.M., Resident A was observed sitting in her wheelchair in activities. At 12:30 P.M. on the same date, Resident A was observed sitting in her wheelchair in the dining room, eating lunch. At 1:20 P.M., Resident A was observed sitting in her wheelchair in the			

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	dining room, teary-eyed. The resident indicated she "did not know why she was crying." CNA # 2 was observed interacting with the resident, and offered to take the resident to activities. CNA # 2 indicated she was not the aide responsible for Resident A. A request was made for a skin assessment and incontinence check at that time. On 2/21/11 at 1:25 P.M., CNA # 1 and CNA # 2 utilized a mechanical lift to transfer the resident to bed. The resident's wheelchair cushion was observed to be wet with urine. The resident's slacks were observed to be soaked through with urine, and the brief was also saturated. Wrinkled indentations from the brief were observed on the resident's buttocks. CNA # 1 indicated she gave the resident a shower before breakfast that morning. CNA # 1 apologized, and indicated she "just didn't have time." The clinical record of Resident A was reviewed again on 2/22/11 at 9:00 A.M. A Physician's order, dated 2/21/11, indicated, "Toilet Q [every] 2 H [hours] during waking hours. 8AM, 10AM, 12N, 2P, 4P, 6P, 8P. Initial in TAR [treatment administration record] each time its done."			

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	This federal tag relates to Complaint IN00086402. 3.1-38(a)			

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F0333 SS=G	Based on interview and record review, the facility failed to ensure a resident with a diagnosis of Congestive Heart Failure [CHF] and Acute Venous Embolism received her twice daily Lasix for 9 days, failed to administer her 3 doses of Aldactone, resulting in worsening of her CHF and subsequent hospitalization, and failed to administer Coumadin for 1 day, for 1 of 3 residents reviewed with medication errors, in a sample of 6. Resident F Findings include: 1. On 2/22/11 at 9:50 A.M., the Director of Nursing provided the current facility policy on "Medication Orders," dated 2/1/10. The policy included: "Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe...Medication orders specify the following: a. Name of medication, b. Strength of medication, where indicated, c. Dose and dosage form, d. Time or frequency of administration...f. Quantity or duration (length) of therapy...B. Any dose or order that appears inappropriate considering the resident's age, condition...or diagnosis is verified with the attending physician...Prior to administration, the medication and dosage	F0333	Resident F no longer resides in the campus Completion Date 3-23-2011All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing the campus will ensure measures to prevent medication errors.Completion Date 3-23-2011Nursing staff have been in serviced on medication errors regarding passing medcations and transcription of medicaton orders/lab oders. Systemic change is physician orders transcribed to the medication administration sheet or treatment administration sheet will be reviewed by two nurses. All nurses and QMAs will complete a medication pass competency now and annually thereafter.Completion Date 3-23-2011Nurse managers will perform random audits of medication administration sheets and treatment administration sheets to review for medication errors or missed labs on 5 random residents 5x a week x one month then 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 month and quarterly thereafter for review and further suggestions/comments.Completio n Date 3-23-2011	03/23/2011

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	schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and MAR are different...or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule...Medications are administered in accordance with written orders of the attending physician...." 2. The closed clinical record of Resident F was reviewed on 2/21/11 at 2:25 P.M. Diagnoses included, but were not limited to, Acute Venous Embolism, Essential Hypertension, and Congestive Heart Failure [CHF]. A Physician's order, initially dated 10/7/10 and 10/8/10, and on the November 2010 orders, indicated, "Lasix 20 mg po [by mouth] daily @ 1600 [4:00 P.M.]" "Lasix 40 mg po Q AM [every morning]," and "Aldactone 25 mg tablet give 1 tablet orally every day." An additional Physician's order, dated 11/26/10, indicated, "[Increase] Coumadin to 2 mg po qd [every day]. PT/INR on Sunday 11-28-10." The November 2010 MAR indicated, "Coumadin 2 mg daily [recheck] PT/INR 11/28." The MAR indicated the resident			

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	155723	A. BUILDING _____ B. WING _____	02/23/2011

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	did not receive Coumadin on 11/30. A Physician's order, dated 11/30/10, indicated, "Coumadin 2 mg daily. [Recheck] PT/INR 12/6/10." A "Medication Error Circumstance, Assessment and Intervention" form, dated 12/1/10, indicated, "Date of error 11-21-10...Nature of error: Medication not given...Injury/describe: wt. gain...Prevention Update, Nursing education, Nursing counseling...." The form did not indicate the name of the medication that was not given. A "Medication Error Circumstance, Assessment and Intervention" form, dated 12/1/10, indicated, "Date of error 11-26-10...Location error found yellow copy of order...Nature of error: no current order for Coumadin was available 11-28, [and] 11-29, Lab not transcribed [and] was missed...Treatment required: [Yes] Lab...Prevention Update, Nursing education, Nursing counseling...." A Physician's order, dated 12/1/10, indicated, "Resume Lasix 40 mg [one] in AM and Lasix 20 mg po [by mouth] @ 1600. Follow up CXR [chest x-ray] on 12-3-10."			

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	A Physician's progress note, dated 12/3/10, indicated, "...Her weight has increased - weight today is 204 pounds. She has not received her Lasix dose since November 21, 2010. Staff report it was discontinued from the MAR in error. Patient continues to be short of breath even on minimal exertion...I did discuss with her about some mistake with her medications which has been rectified and she should be getting her medications to help her with her shortness of breath. I also told her heart [sic] is not doing good and she voiced understanding...Treatment: 1. CHF...Continue Furosemide Tablet [Lasix], 40 MG, Orally, 1 tablet q am; 1/2 tablet in pm, Once a day, CXR [chest x-ray] and labs have been ordered. 2. DVT or embolism [blood clot] of distal lower extremity, Continue Coumadin tablet...." Nurse's Notes include the following notations: 12/7/10 [untimed]: "Residents [sic] wt this AM 202.6 [up] from 199.6 yesterday, 3-4+ pitting edema to Bilat [lower] ext. [extremities]...[Physician] notified...." A physician's order, dated 12/7/10, indicated, "Aldactone 25 mg BID [twice daily], Lasix 80 mg daily, Daily wts...."			

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12/15/10 at 10:45 P.M.: "N/O [new order] rec'd to [increase] Altace to 10 mg PO daily D/T [due to] heart failure...."

12/22/10 at 7:00 A.M.: "Aide told nurse pt. [patient] had SOB [shortness of breath]. Difficult breathing...0805 [8:05 A.M.] N.O. [new orders] to send to [name of hospital]...."

The resident's November 2010 Medication Administration Record was reviewed. Entries next to the Lasix 20 mg daily and Lasix 40 mg QAM indicated: "Order [changed] 11/21/10." New orders for Lasix were not documented after 11/21.

The resident's December 2010 MAR was reviewed. An entry, dated 12/7/10, indicated, "Aldactone 25 mg [one] BID, Upon rising, HS [at bedtime]." The HS entry was not initialed as given on 12/7, 12/8, or 12/9.

On 2/22/11 at 8:50 A.M., during interview with the DON, she indicated the nurse who wrote "order [changed]" on the Lasix orders, was interviewed, and indicated he did not know why he wrote that on the MAR. He indicated he had not received any order. The DON indicated

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	they could not find any other residents who may have received that order. The DON indicated the resident did not receive the Lasix until it was discovered on 12/1/10, due to the resident's weight gain. The DON indicated the Coumadin error happened due to the nurse not transcribing the PT/INR lab order to the TAR, and the nursing staff "knew not to give the Coumadin unless they knew what the PT/INR values were." The DON indicated the resident missed 2 doses of Coumadin. On 2/23/11 at 10:40 A.M., during interview with the DON, she indicated she did not know why the resident had not received her bedtime dose of Aldactone on 12/7, 12/8, or 12/9. On 2/23/11 at 12:10 P.M., during interview with the DON, she reviewed the record of Resident F, and indicated, "It actually looks as if she didn't miss her Coumadin but 1 night, but the lab was missed." The DON indicated the record looked as if the physician was actually notified on 11/30/10, and then ordered the PT/INR for every other day, and so the lab was obtained on 12/3/10. The DON indicated it was not clear in the documentation regarding when the physician was notified of the medication			

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	error or how many doses of the Coumadin were missed. This federal tag relates to Complaint IN00085610. 3.1-25(b)(9)			

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F0514 SS=D	Based on interview and record review, the facility failed to ensure a resident's record was clear and accurate regarding a lab omission and medication error, for 1 of 6 records reviewed for documentation, in a sample of 6. Resident F Findings include: 1. On 2/22/11 at 9:50 A.M., the Director of Nursing provided the current facility policy on "Guidelines for Medication Error Reporting," dated 11/10. The policy included: "...Document the following in the resident's clinical record: a. A description of the error (brief) b. Name of physician and time notified c. Physician's subsequent orders...." 2. The closed clinical record of Resident F was reviewed on 2/21/11 at 2:25 P.M. A Physician's order, dated 11/26/10, indicated, "[Increase] Coumadin to 2 mg po qd [every day]. PT/INR on Sunday 11-28-10." The November 2010 MAR indicated, "Coumadin 2 mg daily [recheck] PT/INR 11/28." The MAR indicated the resident did not receive Coumadin on 11/30. A Physician's order, dated 11/30/10, indicated, "Coumadin 2 mg daily.	F0514	Resident F no longer resides in the campus.Completion Date 3-23-2011All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing the campus will ensure it maintians clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented;readily accessible;and systematically organized.Completion Date 3-23-2011Nursing staff have been in serviced regarding required documentaion if a medication error or omitted lab occurs. Systemic change medication circumstance form has been revised to include - brief description of error, name and time physician notified, and physician subsequent orders.Completion Date 3-23-2011DHS/designee will review all medication errors or omitted labs daily to ensure documentation of events complete with results forwarded to QA committeee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date 3-23-2011	03/23/2011

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	[Recheck] PT/INR 12/6/10." A "Medication Error Circumstance, Assessment and Intervention," dated 12/1/10, indicated, "Date of error 11-26-10...Location error found yellow copy of order...Nature of error: no current order for Coumadin was available 11-28, [and] 11-29, Lab not transcribed [and] was missed...Treatment required: [Yes] Lab...Prevention Update, Nursing education, Nursing counseling...." A Physician's order, dated 12/2/10, indicated, "...PT/INR QOD [every other day]." A PT/INR lab report, dated 12/3/10, indicated a notation: "Has PT/INR ordered QOD [every other day] while on antibiotics...recheck PT INR 12/6." On 2/22/11 at 8:50 A.M., during interview with the DON, she indicated the Coumadin error happened due to the nurse not transcribing the PT/INR lab order to the TAR, and the nursing staff knew not to give the Coumadin unless they knew what the PT/INR values were. The DON indicated the resident missed 2 doses of Coumadin. On 2/23/11 at 12:10 P.M., during			

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	interview with the DON, she reviewed the record of Resident F, and indicated, "It actually looks as if she didn't miss her Coumadin but 1 night, but the lab was missed." The DON indicated the record looked as if the physician was actually notified on 11/30/10, and then ordered the PT/INR for every other day, and so the lab was obtained on 12/3/10. The DON indicated it was not clear in the documentation regarding when the physician was actually notified of the medication error, and of the actual dosages missed. This federal tag relates to Complaint IN00085610. 3.1-50(a)(1) 3.1-50(a)(2)			

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